COMMONWEALTH of VIRGINIA

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June 17, 2013

Saifullah K. Niazi, M.D.
4906 Cutshaw Avenue, Suite 105
Richmond, Virginia 23230

UPS OVERNIGHT

RE: License No.: 0101-024968

Dear Dr. Niazi:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Thursday, August 28, 2013, at 1:00 p.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Henrico, Virginia**. The conference will be conducted pursuant to Sections 54.1-2400(10), 2.2-4019, and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

A Special Conference Committee ("Committee") will inquire into allegations that you may have violated certain laws and regulations governing the practice of medicine and surgery in Virginia. Specifically:

1. You may have violated Sections 54.1-2914.A, 54.1-2915.A(3), (13), (16), and (17), 54.1-3302, and 54.1-3304.1 of the Code in that you maintained in an unlocked desk drawer in your office controlled substances that had been dispensed by pharmacies to patients and then returned by patients to you, which you then re-dispensed in small brown envelopes to other patients (including Ativan (schedule IV) re-dispensed to Patient/Employee Z) in violation of Section 54.1-3411.1 of the Code.

2. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code in that you maintained and administered controlled substances in an unsafe and potentially dangerous manner by virtue of your practice of storing in your unlocked desk drawer liquid injectible medications that you had prescribed to patients, which, after filling, the patients returned to you for you to store and then administer intramuscularly to them when they returned for regular office visits. On or about March 1, 2012, a Department of Health Professions' Investigator observed that you had stored in your desk drawer two open vials of fluphenazine decanoate 25 mg/ml 5 ml, two open vials and two sealed vials of haloperidol

decanoate 50 mg/ml 5 ml, one open vial of haloperidol decanoate 100 mg/ml 5 ml, and two 1 ml ampoules of haloperidol 100 mg/ml, none of which had any patient names, labeling, or other identifying information on them, making it virtually impossible to determine and keep track of the ownership of medications and increasing the risk of administering the wrong medications to patients.

3. You may have violated Sections 54.1-2915.A(3), (13), (16), (17), and (18) and 54.1-3404 of the Code in that you failed to maintain an inventory, updated biennially, of all Schedule II-V controlled substances maintained in your office, including sample medications and medications returned to your practice by patients. Further, you failed to maintain adequate records regarding your receipt, administration, dispensing, and disposal of such controlled substances.

4. You may have violated Sections 54.1-2915.A(3), (11), (12), (13), (16), and (18) of the Code, and 18 VAC 85-20-29.A(1) of the Board of Medicine General Regulations, in that, during 2011-2012, you aided and abetted the illegal practice of medicine by your unlicensed assistants, Employee X and Employee Y, when you allowed and instructed them to see, examine, evaluate, and diagnose your patients, to make treatment and medication decisions and formulate treatment plans for your patients, and to unilaterally prescribe medications to patients (either electronically or via prescription blanks you had pre-signed).

5. You may have violated Sections 54.1-2915.A(3), (12), (13), (16), (17), and (18) and 54.1-3303.A and 54.1-2408.A of the Code, and 18 VAC 85-20-26(C) of the Board of Medicine General Regulations, with respect to your care and treatment of Patients A, B, C, D, and G from approximately 2009 to 2012, in that:

a. You failed to take or document an adequate history or to perform an adequate work-up to formulate your diagnosis of ADHD for Patient A, a 46-year-old female, on or about April 20, 2011; hence, your prescription of Adderall (Schedule II) to Patient A on that date and over the course of the next year was not medically indicated.

b. You failed to take or document an adequate history or to perform an adequate work-up to formulate your diagnosis of ADHD for Patient B, a 33-year-old male, on or about March 30, 2011; hence, your prescription of Adderall to Patient B on that date and over the course of the next year was not medically indicated.

c. Regarding Patient C:

i. You regularly prescribed Lortab (Schedule III) to Patient C, a 32-year-old female, from approximately March 2010 until August 2011 (when she died from a drug overdose), without diagnosing or documenting a medical condition warranting such medication or performing any physical examination or evaluation during the entire treatment period. Although some progress notes

document Patient C's self-report of migraine headaches and back pain, you never performed any diagnostic testing or studies to determine the etiology of such pain nor did you obtain other objective evidence relating to those conditions. Instead, you documented (on or about March 22, 2010 and September 3, 2010) that you would prescribe Lortab to Patient C until she found another pain specialist, based on her unconfirmed report to you that she had been unable to locate a new pain management physician to replace the one who had previously been prescribing her Lortab. However, you failed to obtain any prior treatment records from said specialist to confirm Patient C's account or clarify the nature of her alleged pain conditions. Further, although there is no additional documentation in your record indicating Patient C attempted to find another pain physician, you nevertheless continued to prescribe her narcotics for approximately a year and a half.

ii. You initiated narcotics therapy for Patient C notwithstanding your knowledge of her long and extensive alcohol and substance abuse history, which you documented at the patient's initial office visit on March 1, 2010. Further, you failed to appropriately monitor and manage Patient C's usage of the narcotics and other controlled substances you prescribed her, i.e., you had no pain management/controlled substance contract in place and did not perform any pill counts or urine drug screens or access the Prescription Monitoring Program ("PMP") to ensure compliance with your medication regimen.

iii. You failed to note and appropriately respond to signs of drug-seeking or abusive behavior by Patient C, i.e., receipt of a complaint from a pharmacist regarding her medication usage (documented on or about June 10, 2010), and the patient's request for an early Lortab refill on or about June 2, 2011 based on her report that her nine-year-old son had flushed all her pain pills down the toilet.

d. At his first office visit on or about June 6, 2011, you diagnosed Patient D, a three-year-old, with ADHD, despite the fact that such diagnosis was inappropriate and not medically indicated for a child of that age. Further, you commenced prescribing Patient D Vyvanse (Schedule II) and Clonidine (Schedule VI) for ADHD on that date (and continued to do so thereafter through at least February 2012), even though Vyvanse is not approved or recommended for children younger than six years of age and Clonidine is not approved or recommended for children at all. Subsequently, you added Intuniv and Tenex (both Schedule VI) to Patient D's medication regimen for ADHD, even though Intuniv is not approved or recommended for children under six years of age and Tenex is not approved or recommended for children under 12.

e. You continuously prescribed oxycodone (Schedule II) in escalating quantities/doses to Patient G, an 18-year-old female, from approximately September 2010 to June 2011, without having any bona fide medical rationale therefore or diagnosing or documenting a medical condition warranting such medication. The only documentation in your record concerning your prescribing oxycodone to Patient G is "pain", with no indication of where the pain was located, the history or duration of the pain, what type of pain was present, the quality and nature of the pain, etc. Moreover, although you prescribed oxycodone to Patient G for almost ten months, you did not perform any physical examination or evaluation during that entire period. Finally, you made no attempt to monitor and manage her usage of this medication, via a pain management/controlled substance contract, pill counts, urine drug screens, or accessing the PMP, and took no appropriate responsive action (but instead continued to prescribe narcotics) when Patient G asked for early oxycodone prescriptions on multiple occasions.

6. You may have violated Sections 54.1-2915.A(3), (12), (13), (16), and (18) of the Code, and 18 VAC 85-20-26(C) of the Board of Medicine General Regulations, with respect to your care and treatment of Patients E and H as follows:

a. At Patient E's office visit with you on July 28, 2011, a week prior to the patient's suicide, you failed to record a mental status examination or to ask (or document asking) Patient E about self-destructive or suicidal ideation, notwithstanding the fact that you noted the patient was tapering off of methadone and had a history of prior suicide attempts.

b. During your treatment of Patient H for schizophrenia from approximately 2009 to January 2011, you failed to obtain or order (or document ordering) any baseline or follow-up laboratory tests, despite the fact that you were prescribing the patient Depakote and lithium, medications which require careful monitoring of laboratory levels/values. Likewise, you failed to obtain or order (or document ordering) any CBC labwork for Patient H during this treatment interim even though you were prescribing him clozapine, a medication with potential side effects necessitating such lab work.

7. You may have violated Sections 54.1-2915.A(3), (12), (13), (16), and (18) of the Code, and 18 VAC 85-20-26(C) of the Board of Medicine General Regulations, in that you failed to manage and maintain accurate and complete patient records for Patients A-H. Specifically, your records for Patients A-H are often repetitive, containing the same "canned" boilerplate information over the course of numerous office visits. Moreover, your records for Patients A-H contain numerous inconsistencies and contradictory information that cannot be reconciled and/or is not adequately explained. For example:

a. In each of Patient A-H's medical records, you documented at almost every office visit "[n]o medications are currently taken," when, in fact, you prescribed them multiple medications prior to and at each visit and listed those prescribed medications at the end of the note.

b. In each of Patient A-H's medical records, you frequently documented over the course of multiple office visits that previously prescribed medications were not being prescribed at a particular visit because "patient has supply." However, in numerous instances, your prescriber PMP revealed that you in fact prescribed these medications to Patients A-H on such dates.

c. On or about April 20, 2011, you changed the status of Patient A's diagnosed panic disorder (without agoraphobia) from active to inactive without explaining why or how that condition had changed. Further, on or about September 21, 2011, you documented that Patient A "was seen on an emergency basis due to sudden emotional changes as a result of loss of meds" but failed to document what these sudden emotional changes were.

d. In the case of Patient B:

i. At Patient B's first office visit on August 5, 2010, you documented that the patient had symptoms of depressive disorder with chronic or daily episodes of depression, feelings of sadness, concentration difficulties and irritability associated with depression, and a sad affect most of the time, but inexplicably documented "[m]ood is entirely normal with no signs of depression" in the same note.

ii. On or about August 31, 2010, you documented that Patient B reported to you he recently had a seizure and was taken to the hospital. However, you failed to document any further information regarding that seizure, and instead carried over in your office note (for this and subsequent dates) the same medical history previously documenting that the patient had no seizure disorder.

e. You documented in an office note for Patient C for August 12, 2011 that the patient described continued depressive symptoms, that her affect was sad, and continued your diagnosis of bipolar 2, most recent episode depressed; however, at the same time you documented that the patient's "[m]ood is entirely normal with no signs of depression or mood elevation."

f. In the case of Patient D:

i. On or about June 23, 2011 (and in multiple office notes thereafter), you documented that Patient D needed assistance or cues for self-care tasks and that his ability to do domestic tasks was impaired and required assistance; however, the patient was three years old and would be expected to exhibit those traits and needs. Similarly, you repeatedly documented in Patient D's record that his "insight into illness is poor", which would be expected in a child this age.

ii. Although you had regularly prescribed Patient D multiple psychotropic medications over the prior six months, on or about November 14, 2011, you documented "[n]o active medications" without documenting any reason or explanation for this change in treatment plan. Moreover, at Patient D's next office visit on December 16, 2011, you documented that "[c]ompliance with medication is irregular. He no longer takes prescribed medication"; yet, you noted continuation of the medications you had previously prescribed to him before November 14, 2011 (i.e., Vyvanse, Clonidine, and Intuniv), again without any documented explanation for this change in treatment plan.

g. At Patient E's initial visit on or about December 10, 2009 and subsequently in an office note for March 10, 2011, you documented that the patient had a history of suicidal thoughts, but had never made an attempt. However, in that same line, you documented "[Patient E] has made suicidal attempts. He made a suicide attempt by asphyxiation."

h. In the case of Patient G, an 18-year-old female:

i. At Patient G's first office visit on June 18, 2010, you documented that she had a good attention span and had "no signs of hyperactive or attentional difficulties", but nevertheless diagnosed her with ADHD, combined type, on that date and continued that diagnosis at multiple succeeding office visits.

ii. You documented in Patient G's office note for February 20, 2012 that the patient was having a rough time due to her mother being in jail and facing a long prison time and that she had to move in with her father. However, in that same note you documented that Patient G lived with her mother. Also in that note, you documented that Patient G had both "a good attention span" and "a short attention span."

i. From approximately 2009 to January 2011, medications listed in your office notes for Patient H, a schizophrenic who lived in an assisted living facility, are frequently inconsistent with medications listed for this patient in the Physician's Order Form Plan of Care that you completed for the assisted living facility, with the facility's medication administration record for the patient, with medications listed on psychiatric hospital discharge instructions for the patient, and/or with Pharmacy Drug Regimen Reviews prepared for this patient. Further, on or about June 22, 2010 and June 29, 2010, you

documented the discontinuance of several medications and the addition of several new medications for Patient H, without documenting any reason or rationale for these changes.

Please see Attachment I for the name of the patients and employees referenced above.

After consideration of all information, the Committee may:

1. Exonerate you;
2. Place you on probation with such terms it deems appropriate;
3. Reprimand you; and
4. Impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

Further, the Committee may refer this matter for a formal administrative proceeding when it has failed to dispose of a case by consent pursuant to Section 2.2-4019 of the Code.

You have the right to information that will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the Committee for its consideration when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by UPS overnight mail. These materials have been provided this date to your counsel, William Turner, Esquire.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Reneé S. Dixson, Discipline Case Manager, Virginia Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia, 23233, by **August 9, 2013**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Julia Bennett wish to submit any documents for the Committee's consideration after **August 9, 2013**, such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by **July 8, 2013**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **July 8, 2013**, will not be considered.

Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia cited in this notice can be found on the Internet at **http://leg1.state.va.us**. To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

In its deliberations, the Committee may utilize the Sanction Reference Points System, as contained in the Sanction Reference Manual. The manual, which is a guidance document of the Board, may be accessed at **http://www.dhp.virginia.gov/medicine**. You may request a paper copy from the Board office by calling (804) 367-4513.

Please advise the Board, in writing, of your intention to be present. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions.

If you have any questions regarding this notice, please contact Julia Bennett, Adjudication Specialist, at (804) 367-4427.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

Enclosures:
Attachment I
Informal Conference Package (4 volumes)
Map

cc: Julia Bennett, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
William Turner, Esquire [w/enclosures]
Kim Lynch, Senior Investigator [142183]